

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **12729**

FILED **APR 11 1953** REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **547** Registrar's No. **943**

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Richmond Hts.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Gardenville	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St Mary Hospital		d. STREET ADDRESS (If rural, give location) 8149 Gravois	

3. NAME OF DECEASED (Type or Print) a. (First) Eleanor b. (Middle) Thurmer c. (Last) Thurmer		4. DATE OF DEATH (Month) (Day) (Year) Mar. 28, 1953	
5. SEX female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH June 5, 1860
9. AGE (In years last birthday) 92		10. AGE (In years last birthday) 92	
11. BIRTHPLACE (City and State or Foreign Country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME not known		13b. MOTHER'S MAIDEN NAME not known	
14. NAME OF HUSBAND OR WIFE Frank			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Dr Carl F Kloppel	ADDRESS Box 212 Rt 12
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis ANTECEDENT CAUSES: Malnutrition DUE TO (b) Malnutrition DUE TO (c) Fracture intertrochanteric femur II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Kirk INTERNAL BETWEEN ONSET AND DEATH 3 mo.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Mar 16, 1953**, to **Mar 28, 1953**, that I last saw the deceased alive on **Mar 28, 1953**, and that death occurred at **9:50 P m.**, from the causes and on the date stated above.

23a. SIGNATURE W Schopp MD	(Degree or title) MD	23b. ADDRESS 505 Humboldt	23c. DATE SIGNED 3/30/53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 3/31/53	24c. NAME OF CEMETERY OR CREMATORY Old SS Peter & Paul	24d. LOCATION (City, town, or county) (State) St. Louis Mo.

DATE REC'D BY LOCAL REG. 3-31-53	REGISTRAR'S SIGNATURE Hubert R. Drake - M.D.	25. FUNERAL DIRECTOR'S SIGNATURE J L Ziegenhein & Sons	ADDRESS 7027 Gravois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Neville G. Threlketter

Licensed Embalmer No. *3696*

P. O. Address *7027 Garvin*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.